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LIVING WILLS—NEED FOR LEGAL RECOGNITION

Death is the only certainty in life, the one inevitable event that each of us must face. How we decide to meet and accept death rationally is often no easy matter. Medicine's continuing progress in prolonging life has made the task all the more difficult. Hopefully, in an age when "contingency planning" is idolized, we have come to recognize the need to readjust to and prepare differently for life's only certainty. In our recent attempts to face death rationally, an instrument known as the "living will" has evolved.¹

The living will is a document by which a competent adult signifies a desire that if there ever comes a time when there is no reasonable expectation of his recovery from physical or mental disability that he be allowed to die rather than be kept alive by artificial means or heroic measures.² What the typical living will

¹ Luis Kutner has suggested various other names for the document, including "a declaration determining the termination of life," "testament of death," "declaration for bodily autonomy," "declaration for ending treatment," [or] "body trust"" Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 551 (1969) [hereinafter cited as Kutner, 44 IND. L.J.].

Additionally the Catholic Hospital Association has issued a document called the "Christian Affirmation of Life" which is distributed to terminally ill patients in Catholic hospitals. It is the equivalent of a living will.

² The Euthanasia Educational Council of New York, New York distributes the following living will:

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER—If the time comes when I can no longer actively take part in decisions for my own future, I wish this statement to stand as the testament of my wishes.

If there is no reasonable expectation of my recovery from physical or mental and spiritual disability, I, _____, request that I be allowed to die and not be kept alive by artificial means or heroic measures. I ask also that drugs be mercifully administered to me for terminal suffering even if in relieving pain they may hasten the moment of death. I value life and the dignity of life, so that I am not asking that my life be directly taken, but that my dying not be unreasonably prolonged nor the dignity of life be destroyed.

This request is made, after careful reflection, while I am in good health and spirits. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to take it into account. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing this responsibility that this statement is made.

Note, 10 CAL. WEST. L. REV. 613, 625 (1974).

does, in effect, is to sanction passive euthanasia, or, as it has been called, antidysthanasia.

Euthanasia, literally meaning "good death," has sometimes been defined to include both its active and passive phases.³ The former involves the commission of an act which hastens death; the latter, the omission of an act. The popularized term "mercy killing" is but a synonym for active euthanasia. More often, however, euthanasia is defined to include only its active aspect, meaning simply "the act or practice of painlessly putting to death those persons suffering from incurable conditions or diseases."⁴

The term antidysthanasia, although escaping present dictionary recognition, is a synonym for passive euthanasia, and has been defined as "the failure to take positive action to prolong life."⁵ This note will always distinguish between passive and active euthanasia in order to avoid unnecessary confusion or ambiguity.

The living will is a document which directs one's physician to cease affirmative treatment under certain specified conditions. It can presumably apply to both the situation in which a person with a terminal disease lapses into the final stage of his illness and also the situation in which a victim of a serious accident deteriorates into a state of indefinite vegetated animation. Although living wills are increasing in popularity today,⁶ they are nothing more than a moral directive to one's physician, analogous in effect to precatory language to a legatee in a testator's will.⁷ Having yet to be tested in any court,⁸ they exist without legal force.⁹

³ "Euthanasia [is] a mode or act of inducing or permitting death painlessly as a relief from suffering." Kutner, *The Living Will — Coping With The Historical Event Of Death*, 27 BAYLOR L. REV. 39, 51 (1975) [hereinafter cited as Kutner, 27 BAYLOR L. REV.].

⁴ WEBSTER'S NEW INTERNATIONAL DICTIONARY 786 (3d ed. 1971).

⁵ Note, *Antidysthanasia Contracts: A Proposal For Legalizing Death With Dignity*, 5 PAC. L.J. 738, 738 (1974). The term has also been defined as a "situation in which the person facing an unnatural death from disease or injury hastens his own death by refusing medical attention." Note, *The Right to Die*, 7 HOUSTON L. REV. 654, 654 (1970).

⁶ A 1973 estimate set the number of living wills in the United States at 250,000. MEDICAL WORLD NEWS, Sept. 14, 1973, at 73.

⁷ That the physician recognizes the document as no more than a moral, rather than legal, directive is evidenced by a United Press International survey reported in *Trial* magazine which found that only six doctors in ten would honor a living will. *The Right To Die*, TRIAL, Jan., 1976, at 2.

⁸ *Id.*

⁹ Usually the document itself recognizes that it has no legal validity. For exam-

The living will has failed to gain legal recognition because the law has been unable to answer two crucial questions: (1) Does a patient have the right to refuse life-prolonging treatment, that is, is there a right to die?, and (2) Can a physician, who at the request of his patient abstains from rendering life-sustaining therapy, be held civilly or criminally liable for that abstention?

The doctrine of informed consent forms the basis of every physician-patient relationship. In its most elementary form, the doctrine requires that a physician acquire the patient's voluntary and informed consent to treatment before the physician renders appropriate medical assistance.¹⁰ If the patient is a minor, consent must first be obtained from the child's parents.¹¹ Failure to obtain consent prior to treatment can result in the doctor being held liable to the patient in either a battery or a negligence action.¹² In emergency cases where the patient is unconscious and where treatment is necessary before consent can be obtained, consent will be

ple, the living will created by the Euthanasia Educational Council, *supra* note 2, contains the statement: "[T]his document is not legally binding . . ."

¹⁰ *E.g.*, *Browning v. Hoffman*, 90 W. Va. 568, 581, 111 S.E. 492, 497 (1922); *Mohr v. Williams*, 95 Minn. 261, 269, 104 N.W. 12, 15 (1905). *See generally*, Annot., 76 A.L.R. 562 (1932), *supplemented*, 139 A.L.R. 1370 (1942).

¹¹ *E.g.*, *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941); *Younts v. St. Francis Hospital and School of Nursing, Inc.*, 205 Kan. 292, 469 P.2d 330 (1970); *Browning v. Hoffman*, 90 W. Va. 568, 581, 111 S.E. 492, 497 (1922). In *Bonner*, the Court also noted four exceptions to the general rule: (1) when an emergency exists, (2) when the child has been emancipated, (3) when the parents are so remote as to make it impracticable to obtain consent in time to accomplish proper results, and (4) when the child is close to maturity and knowingly gives an informed consent.

One commentator has argued that a minor should be allowed to give legal consent to medical treatment and has proposed a Pediatric Bill of Rights to effectuate his view. Note, *The Minor's Right to Consent to Medical Treatment: A Corollary of the Constitutional Right of Privacy*, 48 So. CAL. L. REV. 1417 (1975).

¹² Where the treatment is completely unauthorized, a battery action will lie. *E.g.*, *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958). However, where treatment is authorized but the risks of it are not fully disclosed so that a truly informed consent has not been given, the courts are split on whether a battery or a negligence action is the appropriate theory of recovery. *E.g.*, *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (negligence); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) (negligence); *Belcher v. Carter*, 13 Ohio App. 2d 113, 234 N.E.2d 311 (1967) (battery or negligence); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966) (battery). Both the *Cobbs* and *Wilkinson* cases contain excellent discussions on the battery-negligence controversy.

Dean Prosser has concluded that "the prevailing view now is that the action . . . is in reality one for negligence . . ." W. PROSSER, *HANDBOOK ON THE LAW OF TORTS* § 32, at 165 (4th ed. 1971).

implied on the assumption that the patient would have agreed to the emergency treatment had he been able to do so.¹³

Logically, the right to consent to treatment under the doctrine presupposes a right to refuse treatment also. If the patient should refuse the medical services offered, and that refusal fails to jeopardize or seriously threaten his life, there would seem to be little, if any, societal interest in not respecting or abiding by such a decision. But what if that right of refusal, which the doctrine of informed consent professes to protect, results in seriously endangering a patient's life or insuring his premature demise? In that instance, the patient's decision to refuse treatment is more often met with outright disapproval. Time and again when a non-terminal patient has refused essential life-saving treatment, the hospital has turned to the courts seeking a judicial order mandating the treatment despite the refusal of the patient.¹⁴

Probably the most typical situation in which a patient's refusal is challenged in court is in a blood-transfusion case, where the patient, usually on religious grounds, refuses to consent to an essential blood transfusion.¹⁵ Generally, where the power of the courts has been called into play, a judge will order the transfusion

¹³ *E.g.*, *Dunham v. Wright*, 423 F.2d 940, 941 (3d Cir. 1970); *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

¹⁴ *E.g.*, *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964) (comatose patient's wife). See generally, Annot., 9 A.L.R.3d 1391 (1966).

Because the decision to refuse treatment is most often based upon religious convictions, members of the patient's family who share the same religious views do not challenge that decision. *Contra*, *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

Obviously not every refusal to submit to treatment is challenged in court. If the patient is fully informed of the consequences of his decision, his family is in agreement, and a document has been signed releasing both the doctor and the hospital from any possible liability, then it may well be that the power of the courts will never be injected into the situation. For an example of a document in which a nonconsenting patient releases the doctor and the hospital from all attendant liability, see PRACTICING LAW INSTITUTE, PROFESSIONAL MALPRACTICE, FORM NO. 18, REFUSAL TO SUBMIT TO TREATMENT (1967).

¹⁵ *E.g.*, *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), rehearing denied, 331 F.2d 1010, cert. denied, *Jones v. President and Directors of Georgetown College, Inc.*, 377 U.S. 978 (1964); *Raliegth Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

given over the patient's objection, citing various interests which deserve the state's protection and which, under the circumstances of the case, override the individual patient's rights and desires.¹⁶

Nevertheless, there are a few cases in which a court has upheld a patient's right to refuse the life-saving transfusion and thus, in effect, has sanctioned the patient's desire to meet death on his own terms. In *In Re Brooks' Estate*,¹⁷ the Illinois Supreme Court explicitly upheld the refusal of a patient to accept a necessary blood transfusion, finding "no overriding danger to society" which would permit interference with the individual's decision.¹⁸ The same result obtained in *Erickson v. Dilgard*¹⁹ where, even though the court noted that the patient's decision was probably the equivalent of his taking his own life, it held that "it is the individual who is the subject of the medical decision who has the final say"²⁰

The *Brooks* and *Erickson* decisions involve non-terminal cases in which the patient would fully recover if given the necessary medical treatment. However, the living will is meant to deal with cases in which there is no reasonable hope of recovery. Yet if the doctrine of informed consent can be applied to protect the non-terminal patient's right to decide what should be done with his own body, it seems only logical to ask why that same right to refuse medical treatment should not be extended to the terminal patient as well.²¹

¹⁶ *E.g.*, Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964) (state's interest in prohibiting child of patient from being orphaned); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (state's interest in respecting doctor's conscience and professional oath); *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (state's interest in conserving life and respecting hospital staff's professional creed); *Raliegth Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964) (state's interest in protecting life of viable fetus within patient).

¹⁷ 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

¹⁸ 32 Ill. 2d at 373, 205 N.E.2d at 442. In upholding the patient's right to refuse treatment, the court found that: (1) she had been fully informed of the consequences of her actions, (2) no minor children, dependent upon her, were involved, and (3) she had executed documents releasing both the hospital and the doctor from any civil liability.

¹⁹ 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

²⁰ 44 Misc. 2d at ____, 252 N.Y.S.2d at 706. Here, as in *Brooks*, this court again found that the patient was competent and completely informed of the facts, and that no minor children were involved.

²¹ For articles in support of extending the right of refusal to terminally ill patients, see, *e.g.*, Comment, *Informed Consent for the Terminal Patient*, 27

The right to refuse life-prolonging treatment may have constitutional underpinnings which would support it. No less than five amendments to our federal constitution have been suggested as grounds for upholding the right to die.²² One legal commentator has focused on the right of privacy, as the source for support of the right.²³ Whether one's decision to die could be found to be within the right of privacy, and, if so, whether it could withstand the compelling state interest test in every situation is yet to be seen.²⁴

BAYLOR L. REV. 111 (1975); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 260 (1973) [hereinafter cited as Cantor].

²² U.S. Const. amends. I, IV, VIII, IX, XIV.

If the refusal to consent to treatment is due to religious belief, the litigant relies upon the free exercise clause of the first amendment. However, the free exercise clause is not an absolute. See, e.g., *Braunfeld v. Brown*, 366 U.S. 599, 603-04 (1961); *Reynolds v. United States*, 98 U.S. 145, 164 (1878). "Whether a religiously motivated refusal of life-saving medical treatment is constitutionally protected turns on whether there is a valid public interest in the individual's life." Note, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CALIF. L. REV. 860, 866 (1965). An overview of the blood transfusion cases suggests that the courts usually lean toward finding such a public interest and thus deny the refusal. See cases cited note 16 *supra*. The question of whether this same analysis is equally applicable to situations in which life-prolonging, rather than life-saving, treatment is refused, has not been met.

An argument that the fourth amendment may support a right to die could also be made. In *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (dissenting opinion), Mr. Justice Brandeis stated that our Constitution conferred upon each of us "the right to be let alone" and that any intrusion of that right "must be deemed a violation of the Fourth Amendment." This right to be let alone has been suggested as encompassing the right to refuse medical treatment even at great risk. Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1010, 1016-17 (D.C. Cir. 1964) (Burger, J., dissenting opinion).

The prolongation of the dying process through artificial means could arguably be held to be an infliction of cruel and unusual punishment violative of the eighth amendment. Kutner, 27 BAYLOR L. REV. at 40.

An individual's right of privacy, originating from either the ninth or the fourteenth amendment, could be held to encompass the right to die. See notes 23 and 24 *infra*.

See also Note, *Legal Aspects of Euthanasia*, 36 ALBANY L. REV. 674, 679-86 (1972) (constitutional aspects of active euthanasia examined).

²³ Kutner, 27 BAYLOR L. REV. at 46; Kutner, 44 IND. L.J. at 543, 545.

²⁴ The right of privacy has been deemed a "fundamental right" subject to regulation only where a "compelling state interest" can be shown. See *Roe v. Wade*, 410 U.S. 113, 155 (1973). To date, the Supreme Court has held that the right of privacy encompasses and protects "the personal intimacies of the home, the family, marriage, motherhood, procreation, and child rearing." *Paris Adult Theatre I v.*

Perhaps a larger obstacle to recognition of the right to die is the present uncertainty of the law with respect to the liability of a physician who, at the patient's request, fails to render life-prolonging treatment. Undoubtedly, any affirmative act to end a person's life is as illegal for a physician as it is for anyone else.²⁵ Mercy-killing or active euthanasia has no legal sanction yet.²⁶ The more difficult problem is that the legal status of the physician who merely withholds treatment is also in great dispute. Case law on the subject is non-existent. The circumstances under which an act of omission by a doctor will subject him to legal consequences is a question which begs firm resolution.

Legal scholars appear undecided on the answer.²⁸ Some believe that an act of omission by a physician, if maintained at the patient's request, is lawful.²⁹ Others warn that not every act of omission by a doctor is without legal liability.³⁰ The root of the problem may lie in the uncertainty of whether an act is one of commission (active euthanasia) or omission (passive euthanasia).³¹

Slaton, 413 U.S. 49, 65 (1973). Since the Court has recognized the fundamentality of those interests intimately connected with the beginning of the life cycle, it is possible that it would likewise so recognize those interests inextricably linked to the end of the life cycle. If that should occur, then regulation restricting or prohibiting one's right to die could be sustained only upon a showing of a compelling state interest.

²⁵ In fact, the Hippocratic Oath directly forbids any affirmative act by a doctor to take a life. It states, in part, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel"

²⁶ Although mercy-killing is not legal now, legislation permitting it under specific conditions has been proposed. For examples of two such proposals, see Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALBANY L. REV. 826, 853 (1975); Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239, 266 (1970).

²⁷ See Sharp and Crofts, *Death with Dignity - The Physician's Civil Liability*, 27 BAYLOR L. REV. 86 (1975).

²⁸ Cantor, *supra* note 21, at 259.

²⁹ E.g., Kutner, 44 IND. L.J. at 548; Cantor at 259.

³⁰ Such an argument usually presupposes a situation in which a patient has put himself in the doctor's care, and the doctor, without any direction from the patient, abstains from treatment. Fletcher, *Legal Aspects of the Decision Not to Prolong Life*, 203 J.A.M.A. 65 (Jan. 1, 1968); Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967) [hereinafter cited as Fletcher]; Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 MINN. L. REV. 969, 983 n.41 (1958).

³¹ Pulling the plug on a respirator is the typical example. For an excellent discussion of the difficulty of classifying an act as either one of commission or omission, and some suggested criteria, see Fletcher, *supra* note 30, at 1005-14.

Should the latter be clearly defined and its risk of liability removed, "[o]ne would expect rational decisionmaking and more deference to the wishes of the patient"³²

With both the terminal patient's right to die and the physician's liability for recognizing such a right still in a state of legal uncertainty, legislation legalizing the concept of the living will should be considered. To give the force of the law to such an instrument would extend the full scope of the informed consent doctrine to terminal cases and remove any possible liability of the physician who, under the directives of the document, abstains from rendering life-prolonging treatment.

Legal sanction for the living will is not without its problems, however. Moral, as well as legal, arguments stand as barriers to statutory recognition of the document. "The underlying values of our society and the Constitution assert the right to life."³³ The living will asserts the right to death. And, as one commentator has noted:

We are loathe to admit that *any* degree of accident or disease could make it better to be dead. With our advanced medical capabilities, we seem to believe that no condition should be permitted to be fatal, that death is never appropriate, but rather is the final insult to scientific progress.³⁴

Before the document can generate general public approval, the living will must be recognized as "a contribution to the responsibility a thinking individual owes to himself to rationally approach death without terror or anxiety"³⁵

The living will is subject to structural criticism as well. Some living wills written today may be interpreted as approving both active and passive euthanasia.³⁶ An "active" clause, or any lan-

³² Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1663 (1974).

³³ Kutner, 44 IND. L.J. at 539.

³⁴ Reeves, *When Is It Time To Die? Prolegomenon to Voluntary Euthanasia*, 8 NEW ENG. L. REV. 183, 186 (1973).

³⁵ Kutner, 27 BAYLOR L. REV. at 39.

³⁶ Although the Euthanasia Educational Council's living will, *supra* note 2, states that "I am not asking that my life be directly taken," it also states that "drugs be mercifully administered to me . . . even if . . . they may hasten the moment of my death." At least one legal commentator has recognized the patent ambiguity of that latter clause. Sullivan, *The Dying Person - His Right and His Plight*, 8 NEW ENG. L. REV. 197, 215 (1973) [hereinafter cited as Sullivan]. In the

guage within the document which suggests such a practice, should be eliminated. Sanctioning active euthanasia is nothing more than the authorization of an affirmative act which would destroy another human being. Such a proposition is manifestly more opprobrious to our human instincts than an act of omission that accomplishes the same result, and is therefore less likely to meet with legislative support. Moreover, as one legal scholar has noted: "If affirmative medical conduct is prohibited, the patient is allowed maximum opportunity to change his mind and demand treatment."³⁷ Additionally, since an act of commission to hasten death is undeniably criminal, whereas an act of omission is not explicitly so, "no statutory changes are needed to sustain refusals of treatment."³⁸

Other clauses in living wills suffer from simple ambiguity.³⁹ The clause which states that the individual wishes to die if there is no reasonable expectation of his recovery is the best example of uncertain language. The obvious question raised by this language is who is to decide when there no longer exists any reasonable expectation of recovery, and by what standards?⁴⁰ The critically-

absence of any clarification, it is submitted that the clause can be interpreted to allow the practice of active euthanasia or mercy-killing.

Furthermore, some living wills may not even contain the prohibitory clause noted above (for example, "[I] am not asking that my life be directly taken"), thus giving added viability to the hypothesis that the document can be interpreted as sanctioning active euthanasia. For an example of such a living will, see Sullivan at 215, n.55.

³⁷ Cantor, *supra* note 21, at 261.

³⁸ *Id.*

³⁹ One critic of the document has cited four clauses as uncertain at best: (1) "If the time comes when I can no longer take part in decisions," (2) "no reasonable expectation of my recovery," (3) "kept aloft [sic] by artificial means," and (4) "drugs be mercifully administered." Sullivan, *supra* note 36, at 215.

⁴⁰ Thankfully, if the condition of the patient ever regresses to the point that the question becomes, not whether a "beyond-recovery" state has been reached, but whether the patient is in fact dead or not, statutory guidelines are available. In 1975, the West Virginia Legislature passed a bill defining death. W. VA. CODE ANN. § 16-19-1(b) (Cum. Supp. 1975) provides:

"Death" means that a person will be considered dead if in the announced opinion of the attending physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous respiratory and circulatory functions; or, in the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

injured patient in the emergency room, who, if not already bordering on a vegetative state, is probably unconscious, surely cannot make the decision for himself. And the patient suffering from a terminal illness may be either so heavily drugged or in such great pain that the physician properly judges him incompetent to make the final decision. The attending physician may be the most likely person to decide when affirmative treatment should cease, but members of the unfortunate victim's family may have a different viewpoint. The question is not easily dismissed.⁴¹ Obviously, every clause must be meticulously drafted. Perhaps the statute giving legal recognition to the living will should prescribe a specific form that would govern its content and, hopefully, resolve its ambiguities.

The living will is a document that any competent adult should be allowed to execute. Because of its effect, the same type of restrictions governing the power to give informed consent should apply in determining who can make a living will. Thus, neither an incompetent nor a minor could execute such an instrument. Nor would a parent be allowed to make a living will on behalf of his child.

The enabling statute should require that the document be signed in the presence of two witnesses and notarized. Copies of it could then be delivered to one's spouse, physician, lawyer, and clergyman. If the length of the "will" permitted, it might be reduced to card-carrying size so that the individual could carry it at all times to be prepared to meet emergency situations.⁴² Written revocation or amendment of the document would be permissible at any time before the individual reaches the physical state which brings the instrument into play. If oral changes are allowed, impartial witnesses should be present as a procedural safeguard.

There is little doubt that at one time in the history of medical practice, the physician, enamored with the rapid advance in medical capabilities, and the layman, in awe of medicine's seemingly

⁴¹ A "hospital committee, board or a committee of physicians" to make the determination "as to whether the condition of the patient has indeed reached the point where he would no longer want any treatment" has been suggested as one solution. Kutner, 44 IND. L.J. at 551.

⁴² The suggestion that a living will of card-carrying size be produced was triggered by a similar provision suggested for those individuals who wish to make anatomical gifts. See W. VA. CODE ANN. § 16-19-4(b) (Cum. Supp. 1975).

infinite progress, subscribed to a "prolong life at any cost" philosophy. Such is not the case today. Although we still cling to a desire for life, society is slowly realizing that death, like life, must be faced rationally. For centuries, enlightened democratic peoples have strived to provide a life with dignity for every individual. A death with dignity is an equally admirable goal.

James C. Turner